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>> ROARA MICHAEL: Good afternoon, everyone, and welcome to the SAMHSA / HRSA Center for Integrated Health Solutions Webcast titled, Leading Wellness: Peer Providers on Integrated Care Teams. My name is Roara Michael, CIHS Associate and your Moderator for today's webinar.

As you may know, the SAMHSA / HRSA CIHS promotes the development of integrated primary and behavioral health including mental health and substance use services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider setting.

In addition to national webinars designed to help providers integrate care, the Center is continually posting practical tools and resources to the CIHS website, providing direct phone consultations to providers and stakeholder groups and directly working with SAMHSA PBHCI grantees and HRSA funded safety-net settings.

Before we get started, a couple of housekeeping items. To download the presentation slides, please click the drop-down menu labeled Event Resources on the bottom left of your screen. The slides are also available on the CIHS national Council website located under About Us\webinar. During today's slide presentation your slides will be automatically synchronized with the audio, so you will not need to flip any slides to follow along. You will listen to audio through your computer speakers, so please ensure they are on and the volume is up.

You may submit questions to the speakers at any time during the presentation by typing a question into the Ask a Question Box in the lower left portion of your player. Finally, if you need technical assistance, please click on the question mark button in the upper right corner of your

player to see a list of frequently asked questions and contact info for technical support if needed.

Finally,  the views, opinions and content expressed in this presentation do not necessarily affect the views, opinions or policies of the Center for Mental Health Services The Substance Abuse and Mental Health Services Administration, or the Department Of Health And Human Services.

Now I, would like to hand it off to Larry Fricks to introduce today's speakers.

>> LARRY FRICKS:  Thank you, Roara, and welcome to our SAMHSA / HRSA national webinar, "Leading Wellness: Peer Providers on Integrated Care Teams."

According to SAMHSA / HRSA, peer providers are the fastest-growing workforce in behavioral health, and at CHIS,  we are focused on that workforce moving into integrated health and their role on treatment teams. Emerging research shows peer providers are particularly good at activating self-management for whole health chronic conditions.

We are pleased to feature on this webinar a PBHCI grantee site in Tucson, Arizona, Assurance Health and Wellness.

Our presenters, we have Christian Moher, M.D. And Christian is a family doctor  and Chief Medical Officer at Assurance Health and Wellness. He is passionate about integrated care, rock music, and the University of Arizona Wildcats. Go Wildcats!

Then we've got Joddi Jacobson, a good friend of mine, Joddi serves as Director of Individual and Family Affairs Assurance Health And Wellness as an integrated care center where she supervises a growing force of 20 peer specialists. She is someone in long term recovery from substance abuse and she's passionate about the impact that peers play in activating self-management. Her years in behavioral health and her own personal journey

has given her a unique perspective in developing a recovery culture at her agency. She has a degree in Psychology and is currently pursuing her Masters in Social Work. She has won numerous awards and Joddi, we're looking forward to hearing a little bit of your story.

Then, Dr. Christine Wells. Dr. Wells is a psychologist who has worked in community behavioral health for 25 years. Since obtaining an MBA 15 years ago, she focused on program development and healthcare management. The last three years, she's been involved in development of a fully integrated care clinic for low income individuals.

So, I think we over went over, Roara went over our Center and sort of an insight into the PBHCI program. But I'm going to go to the next slide. So, the learning objectives today, when we are through the webinar you should be able to identify the multiple roles and contributions of peer providers within an integrated care setting, evaluate the impact of peer providers on member engagement, satisfaction, health and healthcare costs, and understand the value of peer providers in fostering a culture of recovery and wellness.

We're going to start out with a poll question. We've got two poll questions. The first poll question, how many peer providers do you employ at your program? And if you will just respond to that, Roara will immediately track the results and then will share them.

>> ROARA MICHAEL: Alright, we will give everyone a couple more seconds to fill this out. So, it looks like 17% have zero peer providers employed at their program. It looks like about 21% have 1 peer provider. 9% have about 2. 8%, three peer providers. About 7%, employee four peer providers in their program. And about 38% have 5 or more peer providers employed in their program.

>> LARRY FRICKS: Thank you, Roara, and we're going to go to the next poll question. How many peer providers serve on integrated health care teams at your programs? Go ahead and choose 0, 1, 2, 3, 4, 5 or more.

>> ROARA MICHAEL: All right, just a couple more seconds to go ahead and fill out that poll survey. So we have about 42% who have zero peer providers who serve on integrated healthcare team. 19% have 1. About 11% have 2. 6% have 3. 3% have 4 and 21% have 5 or more peer providers serving on integrated health care teams in their program.

>> LARRY FRICKS: Okay, thank you. After this presentation -- and some of the stuff we're going to hear are these great outcomes -- hopefully that number will increase. So at this time, I'm going to turn it over to Dr. Christian Moher, who is Chief Medical Officer of Assurance Health and Wellness. Thank you, Dr. Moher.

>> CHRISTIAN MOHER: Thank you very much, Larry, for that awesome introduction, and thank you for hosting us today. I've got to tell you that my picture would look much different today. I have a much cooler beard now than I used to -- more like Larry's, but not quite as cool as that.

It is an honor to be here speaking with you today. I am a family doctor, I'm not a psychiatrist. So that gives me a slightly different point of view than many people in the mental health community. I 100% believe that primary care is mental health care, and that without a healthy body, it is very hard for me to be mentally well. But I also believe that mental health care is 100% primary care. I know it's impossible for me to be healthy physically if attention and care are not given to my mental health. That includes the social determinants of health like employment and housing.

I can tell you that the introduction of peers has changed my practice and changed my life. The model of peers that we have developed with Dr. Wells and [indiscernible] with Joddi in our peer program makes my job and every physician's job so much easier. I can tell you that without a doubt I would never work without having peers again.

Our peer model is the heart and soul of our program. I think in some ways our members take the peers more seriously than they do the doctors -- and probably appropriately so -- because it is inspiring to have somebody working with you that's been where you are. It's inspiring to be with someone who has been through substance abuse or alcohol abuse or has PTSD or has some other reason to have been disenfranchised from the medical system. And our peers are awesome at making people feel comfortable and helping us educate our members about their mental and physical well-being, and really, are really the linchpin of what we do in our model.

We had one particular patient who was fairly typical in our clinic. He was in a high needs, high-cost quarter of our system. This guy was using every drug known to man. occasionally violent, and living with one of our other members, who was a vulnerable female adult.  And she was actively trying to get pregnant at that time. He was in the top five patients as far as the cost in our entire system. Not just our program, but in the entire county, and our entire system of care. We could not reach him.  He would not engage. He wouldn't come in to the clinic. He wouldn't meet us any place. He wouldn't answer the door if we came to his house. He bounced around from hospital to hospital, from ER to ER, from inpatient facility to inpatient facility. So finally, one of our peers had an awesome idea. He and I decided that we would do a home visit together but this time, we stopped at Little Caesars on the way over and we spent five dollars to get a large pizza. And this time we knocked on the door, oddly enough, he opened the door and let as in. This peer figured out how to get us back in the door, which is pretty awesome.

We formed our company in a brick warehouse in downtown Tucson. We literally got a bunch of smart people together -- and then they were kind enough to invite me, as well -- and we sat around a table and we discussed how we thought health care should be. What we wanted in our providers, what services we wanted available for our friends and our family. And we made a wish list of all the things that we thought were critical to deliver that care. We were first off wellness.

We started as a wellness program,  a nine week program for adults with mental illness who are in the state Medicaid system.  We have classes from 8 o'clock in the morning until 4 o'clock every weekday. These classes are taught by a personal trainer who teaches stretching and and strengthening and yoga. We have doctors teach classes. We have nurses that teach classes. We have a PhD in nutrition who is one of our members' favorite people on the planet. She not only teaches classes, but she also does a demonstration in our kitchen. We have pharmacists, and then we have peers who are also presenting in classes. Like I said, we have an industrial kitchen. We serve breakfast and lunch to our members every day. It not only serves that [indiscernible] food but it doubles as another classroom so we can teach members how to shop for food that is healthier than what they normally eat and also how to prepare it for themselves and their families.

We opened that wellness program in about July 2014 and did really well with that. We had a really positive response from members and a really positive response from our payers, which was Community Partners at the time. After about a month, they wanted to make us a full-fledged intake provider, their agency. And they wanted integrated care. So we got the same group of people around the table in that warehouse, and we really designed a system that we thought would deliver the best care to the most amount of people -- and, peer support was a huge part of that program. We built our program from the ground up based on a full integration of mental health care and primary care. Not a co-location, it is really hard to shoehorn primary care into a mental health facility and also, there are models of having mental health delivered in a primary care spot, but there are some barriers we felt, to that, too. So we designed our entire system to be fully integrated from the ground up

We became, at around of and of October, early November 2014, the first outpatient clinic in Arizona granted to be integrated care license. We know that because the state did not really know what to do with us. They did not know how to survey us. They didn't really have their act together that time. So they actually sent 2 people down to survey us -- one from

the mental health side of the equation, the other from the primary care side of the equation. They had several meetings where they tried to figure out who was in charge and ultimately, we got our license. So in about 12 weeks, we were able to get a fully up and running integrated care clinic running in Tucson.

I think recruiting the right people is critical for this model. And I cannot stress that enough. It says on the slide everyone starts with the right physician. Maybe that's true. But I think really, it involves everybody that we recruit on every level from the person who's answering the phone and welcoming people at the front desk to our people in peer support and  food services. You really have to have the right spirit in people. We need leadership from physicians. We need people who are willing to go out on a limb for their patients, who are advocates for integrated calendar care, for mental health in general, who want to work hard.

The other side of that is they have to be accessible. If you have a doctor who stays in his or her office all day long, who has a closed-door, who is too busy to take time to answer questions from caseworkers or peer support, it does not work. That is not integrated care to us. Until recently when we were acquired by another company, my desk was literally in a cubby in the bullpen with everyone else. So I was surrounded by caseworkers and peer support people. I was, I think, the definition of accessible at that time -- maybe a little too accessible, every once in awhile you do want to get the work done. But I can tell you, having a doctor that is available and that is energetic and that has enthusiasm to work with caseworkers and peers really sets the stage for our entire system.

Certainly, technical competence is important. You have to be good clinicians both on the psychiatric and primary care side. Learning how to deal with electronic records is something that we all have to do. And I hate them and I will talk a little bit about that later. But they are just part of our lives right now. They make some things easier in some things harder.

Being flexible is huge. These patients do not arrive on time. Sometimes they are an hour late. Sometimes they are a day early. Sometimes they show up a week late. If you have doctors that don't, who won't see those patients, then that's another reason for our members to not trust the medical system. It's another wall, another barrier to prevent them from getting good care. So we try to be really flexible. You have to be flexible with your time. You have to be available to take phone calls for outside consults at anytime of the day.

And what really defined Assurance when we started with our entrepreneurial spirit. We are all about the hustle. And we would like to chase shiny things. If there is a deficiency in the market that we feel we can swoop in and meet the demand, then we are going to go for it and we're going to do an awesome job with that. That is one of the reasons we got along so well with our payers early on. We were up for anything. We would take the hardest cases and their hardest projects and try to do our best work. And sometimes we were awesome at it and sometimes we fell flat on our faces. But that's kind of the spirit of being an entrepreneur. You have to be willing to fail. And that is okay. You have to give yourself permission to fail. You brush yourself off, you get up, and you do it again.

Back to electronic records, which are the bane of my existence, I really don't like electronic records and ... we looked all over the place to find an integrated record, to find a record that was as good at mental health as it was at primary care, and we did not find it. So we found, potentially, a mental health version of a primary care electronic health record which hasn't been ideal, but I think we're getting there. We've had a lot of work done by the company that is sponsoring that. The greatest thing about an electronic record is that everybody has access to the chart. We have access to an integrated care plan. I can see, as a primary care doctor, what someone talked about with their psychiatrist or with their therapist. I can see what the caseworkers did at their last home visit. On the mental health side, they can see what medications I'm prescribing, when they were last in the hospital.  We are plugged in with

our health information exchange here in Arizona. That is critical for knowing where our patients are so that we can meet them where they are at.

Again, I don't think the perfect electronic health record exists. But I do think there are a lot of decent products out there that we can work with.

Focusing on whole health is critical. The point of this whole talk is the emphasis on wellness recovery, and that is where we live and breathe. I think everybody reads the papers. We know about the opiate epidemic. We know about drug abuse. We know about alcohol abuse. We are fully enmeshed in the industry and we love it. That is what we're passionate about. We love helping people because we have been there ourselves, many of us, or we have family members or other friends who have gone through mental health issues, substance abuse, alcohol abuse. And we're really, really passionate about taking care of those people. And then, we were lucky enough to be a SAMHSA / HRSA grantee for behavioral care in 2015. That was a nice feather in our cap and hopefully we are doing a good job for SAMHSA with that money.

In July 2014, we started that wellness program I talked about with about 10 members. By November 2014, we had about maybe 40 members when we opened our clinic. Then we fast forward to today, which is April 2017. And our little clinic in South Tucson has grown to about 2500 members in South Tucson and our company has grown to over 20 sites throughout southern Arizona and we care for over 7000 patients at these sites.

Our growth has been unbelievably fast and that has caused some major growing pains at times. It is really easy to keep your model near and dear to your heart and just have it work in your facility. It is very hard to export that model to other places. We have a clinic in Phoenix. We have another three or four clinics in Tucson, then we have 16 or 17 rural sites, basically from Yuma to Bisbee, which is all southern Arizona. Some of those sites are telemedicine sites and some are in person sites. But we had as our goal to have integrated care and all those sites and we are

working on defining that and exporting our culture of entrepreneurship to those sites.

Our model is based on having a content expert, this means someone like a nutritionist, or a pharmacist, or a doctor, or a nurse and they are paired with a peer. Then they teach the classes together. Then, the peer's job really begins after, as they spend time with the member both on-site and at the member's home. We found that having a peer allows clients to open up and to be more receptive, to be inspired, to be engaged, and ultimately, to be more successful in meeting the wellness goals.

You can see on this slide that we have grown a ton. I mean, it is difficult keeping up with our growth. I miss the days when it was just Joddi and Christine and I and a couple others and we knew everybody. We knew everybody that worked there and we knew everyone that was in the program very, very well. And those are the days that were really my touchstone for integrated care. So I felt like I was doing awesome work. Now I feel a bit spread thin doing administrative work and other stuff, but I still think back very fondly on those days.

Some of our successes that we've had include our Member and Family Advisory Council (MFAC), oddly enough made up of members and families. We have a pretty high level of attendance and peer participation in this program. And these guys and girls give us constant feedback and advise and help us to tailor our program so that we can meet their needs. One of the amazing things that came out of this program is that we now teach zumba at our facility.  We have a whole gym, they wanted to do zumba, so we now do zumba. We have yoga. We have a bunch of other stuff like that that came out of our peer-run organization.

We have a Chronic Disease Management Registry. I think all of us are starting to get anxious if we are not already having a full on panic attack about value-based purchasing. I think our Chronic Disease Management Registry is going to help us better modify our processes and

workflows to better serve our members and also to meet the deliverables that we have to our payers.

Our Diabetes Self-management Program is one of my favorite programs. It's taught by our nutritionist who has a PhD in nutrition and has forgotten more about nutrition than I will ever know. But then, also started by one of the most amazing peers that I know and this person lives and breathes diabetes self-management and really made this his passion project. His name is James and he is a true evangelist for this diabetes self-management program. He has been very, very...this program has been very successful thanks to our peer  and our nutritionist support.

My favorite program is our Opiate Reduction and Chronic Pain Management program. I came of age as  a physician in the late 90s, early 2000s. I was part of the group where we made pain the fifth vital sign and we were trained to be very, very aggressive using narcotics to treat chronic pain. We were assured that we would not cause addiction problems as long as we were treating chronic pain. Everything was on the up and up. Now, fast forward to now, we find out that the pharmaceutical industry was behind a lot of those studies. So I prescribed a lot of opiates over my career -- not excessive amounts, but probably more than I should have and that is because the way I was trained. And I feel like I have been part of the problem, of the opioid epidemic in this country, and I'm very thankful for the Surgeon General now and his work in reducing this.

We started our own program after reading what was coming out at the Department of Health and Human Services and the research on this about a year and half ago. The benefit of being a quick company, a lean, agile company, and entrepreneurial company, is that if we decide to do something, we do it. We don't sit down and go through a bunch of committees to get it approved. I basically decided I was going to do this for my patients. I sent out a letter in November 2015 giving a six-month lead time to tell patients we could no longer continue to prescribe opiates like we had done in the past. That because of the new data, we were changing our philosophy of care and we were going to be with them, we

were going to hold their hands, but we were going to work on getting them down of their high doses of opiates, at least to a safer level, if not entirely.

I had peer support for that. I had technical support for that. I had a lot of support from our therapist and caseworkers and also a lot of angst and stress from them, as well. What is this announcement going to do to our patients? Are we going to send our patients away from here and they're going to go to the ER or urgent care to get their opiates? How is this going to work? I was a little anxious about that myself. But we were able to step up. I had established a relationship with many of these patients from many years, they followed me from my prior practice. So we worked together. A couple of them left but the vast majority stayed. And we were able to reduce our chronic opiate prescribing by over 70% in that first 6 - 12 months. We continue to work on that in our chronic pain management support was a huge part of that project and something that we are very proud of.

We are fully integrated. We have interdisciplinary team meetings every week to make sure we're all on the same page. That's very good for my personal mental health to know I have a psychiatrist, a pharmacist, and a nutritionist available to help me with difficult cases. We scheduled time together not only to talk about difficult cases but to talk to each other and make sure we are okay, so we are a great support for each other.

I had a perfect case just yesterday, I was at the clinic yesterday morning. A very nice man who I've been taking care of for about two years who has non-Hodgkin's lymphoma and who had been lost to care for a few months, I hadn't seen him for maybe three months. I saw him and he looked awful. He looked terrible. I asked him what was going on and he started sobbing hysterically. This is I think, 8:15 a.m. yesterday morning. About a month ago a friend of his had died and that friend had died from the same type of cancer that this man had. A week after that, another friend of his overdosed when the police were trying to take him into custody, so he swallowed all his drugs and he died. Then, this guy's girlfriend had

broken up with him as well, so he was now homeless and living on the streets. For the last three weeks, he had been drinking everything that he could get his hands on every day. For the entire day. From the moment he woke up until the time he went to bed.

I made sure he was medically stable. I took his vital signs, did an exam. Then I was able to get our enrollment specialist into the room and we re-enrolled him with our services. We could not do a full intake because he was intoxicated at the moment, which kind of puts a damper on things. But we were able to get a peer support person in that room and get him into inpatient detox and get a ride for him there within an hour. That wouldn't happen in any other office that I know of. I could tell you, if I was at my prior private practice, we probably would have called the ambulance for this guy and he would've gone to the hospital or to our crisis response center, whatever version of that you guys have there. And he would've cost the system much more money, it would've been less efficient for the patient, and we wouldn't have known where he was going to, what would happen. But because of our peer support program and our active enrollment team, we were able to get him enrolled in that service within an hour.

Our programming is pretty extensive. We have primary care services for adults, outpatient behavioral health services for children and adults. We had primary care for kids at one point in in time, we are working at getting added that back, because a lot of our kids have autism spectrum disorders or other health conditions like diabetes or asthma. Having a primary care doc is critical for the [indiscernible] of our team.

We have intensive outpatient services for substance abuse. Like I said we have a nutritionist who is one of our my favorite people on the planet, one of the smartest people on the planet, and she lives and breathes nutrition and it's been great for our patients and our staff as well.

We have a pharmacy embedded there. We don't dispense medications but we have a clinical pharmacist in the clinic with me and our other providers available for consultations with the physicians and also available for

medication therapy monitoring. She has pharmacy students and pharmacy residents and she often does one-on-one consultations with patients, regarding their medication. Specifically, if I have someone with diabetes or high blood pressure I can start them on a medication, order some labs, and then a week or two later, have the pharmacy team follow up with them. They are able to adjust medications.

Because we are all integrated we chat with each other all the time. We have this all on electronic record. We have a seamless transition and it's good for the patient. You want every person there working at the top of their license. Instead of me seeing a patient for a routine follow-up visit I'm able to see someone else who really needs to be seen that day and that works great.

In the bottom right corner you can see our wellness services are what started us. We were literally birthed in wellness. That program that we provide is now staffed by some of the best people that I've ever worked with. We are very actively trying to get people physically active, trying to get them taking care of in their nutrition status as well. We have some evidence-based programs that we use for tobacco cessation, the In Shape program and some of our other programs that we use to try to get outcomes. Because that's what we're all going to be held accountable for, so we entirely believe in getting these outcomes.

Then at the bottom I talked about our Chronic Disease Management already. Every one of these programs that you see on the page in front of us has peers involved. Our peers are critical to what we do. We are outcome-based as we I said, and we are team approach. Our team approach is critical to our success. The people we recruit to our system, we can't have a bunch of doctors who feel like they are the alpha in the room. We need to have team players or the program doesn't work. We build in time each day for collaboration and coordination of care, three daily huddles where we review the record together and we address any gaps in care as well as the educated care plan.

And this allows us to hook in our peers and our case managers for them to empower and engage the member, to help them get their medication, get their labs done, get their mammogram, get their eye exam done. The peers are awesome in coaching them for their appointments, having them formulate an itinerary of what they want to get done at that appointment and actually coming to the appointment. The peers take notes during the appointments. They keep members engaged at all times. Like I said before, I would never work in a place where I didn't have a peer. This is kind of talking about our team-based collaboration and coordination registry, we try to use evidence-based interventions to get our point across.

This is our healthcare team. It is no exaggeration to say that the peers that we work with are the most important members of our healthcare team. They provide members with a level of trust and comfort that allows them to become engaged with their care. By pairing peers with case managers we can support a caseload of members and make sure we actively address any gaps in care.

From the primary care perspective, peers make my life easier. I think that's the key selling point for doctors, nurse practitioners. Getting peers involved will make your life so much easier. It helps patient compliance. That helps patient engagement. Patients are ready for their appointments. They bring their medications with them to their appointment. Help with medication compliance and also follow up concerns with preventative services [sounds like] are completed. The are building trust between the member and the peer and that helps build trust between the member and the doctor.

The success of this program comes from its leader, the excellent Joddi Jacobson. I think that is the end of my part.

>> JODDI JACOBSON:  Thank you, Christian. Hello everybody, thanks again for joining us. My name is Joddi. I have the honor of talking about a topic that means a lot to me. That is the incredible impact that peer

providers are having on integrated teams and more importantly on our members.

I personally lucked out. I got to start here in the beginning, also, and I got to get the best job in the whole agency, and that is supervising the peer support. As a peer support myself, I have a deep understanding of the power that peers have to help activate and encourage our members to know that they are not alone. I think there's something really powerful about the willingness to disclose their own personal stories that really build trust with our members and give people hope in a time that maybe they have no hope.

So, I'm going to tackle my own gigantic fears and take a deep breath and touch briefly on my own personal experience. This is generally how I'd like to start any talk is just, talk about the thing that scares me the most for the darkest time in my life. Not really!

So the scariest moment in my life was really when I found myself completely hopeless and where I felt like I had no way out. By "no way out," I mean that is not only symbolically, but literally, I was incarcerated. [LAUGHS] and, detoxing off a drug I swore I would never do. I can tell you that I was definitely not living the dream. I remember thinking, "My god, has it come to this?" And the answer was, of course, yes. Because apparently, they put people in jail that break the law and that is what I had done.

My first experience with drugs was at a very young age. I was 11. I can still remember exactly how I felt like, I could breathe for the first time. Like I had been underwater my whole life. The truth is, alcohol and drugs worked for me for what felt like a long time. But, by 15, I was well on my way. By 15, had dropped out of school. I had moved out of my house. I was using a variety of different drugs. I was trying to set up parameters that I would only drink on the weekends or I'd only do a certain amount of these drugs. And I was really never able to hold those limits that I was setting. But I did still have some morals, mind you. I

had a line in the sand that I would absolutely never use heroin. By this point I was experimenting with a lot of different drugs but I was definitely not going to be using that.

By the time I was 19, my life was swirling out of control and I would enter the first of double-digit treatment centers. I guess I was a high utilizer, high-cost member. [LAUGHS] I was definitely in and out of the hospital and in and out of rehab, and getting some sense of sobriety followed by a worse relapse. I think mostly, I was always really trying to find some kind of loophole where I could maybe pull off doing some of the things that were suggested by people and have this great life and great friends and still be able to get high once in awhile.

So that didn't work out well for me, [LAUGHS] but ultimately, I did manage to stay sober once I had really tapped out. The truth is when I think about it, I think what helped me the most in getting sobriety was some incredible women that had lived similar situations as me. So I believed them. Although we didn't call them peers, they were people in programs that I had went to that had gotten sober and stayed sober. And they helped me walk through my life by really setting small goals, which really included just, don't get high today. Just stay sober today. So I managed to stay sober for many years. My life changed incredibly.

Then, I had an injury that would turn my life upside down again. And I was given a prescription for pain medication. And since I never had a problem with opiates, and I'd been sober a long time, I was naïvely unconcerned. So, as the doctor continued prescribing, I continue taking them. This continued for a little over a year. When I was also on the opiate reduction plan, the plan was, "You're done, we're not prescribing you anymore opiates." [LAUGHS] Unfortunately, by this time, I was heavily addicted to OxyContin. Without them, I could not function -- physically, emotionally, really, in *any* way.

So, I began buying pills on the street and started using other street drugs. I was fast approaching the line I swore I would never cross. When

the pills became harder for me to access, I was introduced to a drug that would change the course of my life. My last holdout:  heroin.

This drug took me quickly and I was really watching myself die with my eyes wide open. I didn't have the great luxury of denial that I had when I was younger. I wasn't 19 anymore. I was married to a drug and alcohol counselor. All of my friends were in social service, they were other therapists or something along that line. So I knew I was killing myself and had all intentions of, I was gonna stop. I was always gonna stop tomorrow. Then I had my first encounter with the Criminal Justice Department. I had always lucked out and managed to not get in any trouble. I got arrested for possession of narcotics.

During this time, my husband died of a drug overdose from prescription medication. So here I was, again, I was getting real close to the end now, because things were real, real dark. So I promised God, the universe, and whoever  listened that I was almost done. I was almost done. Like, please don't arrest me. Apparently, my intentions were not sufficient for my probation officer and I was, indeed, arrested. And I detoxed off of heroin in jail, and spent four of the longest months of my life. And I definitely experienced powerlessness in a way I had never imagined.

I think I didn't want to do this anymore. I was just so tired of destroying my life and rebuilding it. And I remember praying that this experience would not be for nothing. I was committed to change my life. And I knew from my experience of being sober for a lot of years that this was something that I probably could not do alone. So, I reached out for help, for people. Fortunately, I had a support system and I had people that we now call peers in my life that could help me walk out of this.

So although I was not grateful at the time for this experience, it really allowed me to change the course of my life. And I definitely think the single most thing that helped me change was the women in my life that helped me walk through this mess.

So, fast-forward, ultimately, this experience was not for nothing. It led me on a personal and professional path where I could use what happened to me as a tool to help others recover. So that was truly a gift.

So now, on to talk about things I'm really passionate about and about the gifts that makes our peer staff uniquely equipped to help members with self-management skills and really to find hope in their lives again. Here [inaudible] peer support which become navigators in a variety of ways. I think, like Dr. Moher talked about in the beginning, there were two of us, two of us running a wellness program. Wow, how things change. Now we have a variety of different navigators or peer supports doing a lot of different roles. So we have peer support with case managers and they are called healthcare teams. So these peer supports are doing things in the community, about 80% of it is in the community. But they will help with community resources, attend doctor's appointments, help members with health literacy and healthy cooking and exercise. And really, meeting the member where they are at to find out what kind of help that they would like.

Then we have employment and housing specialists, which are, I think, huge for our agency, because it's really difficult to start to look at some of the health concerns you have if you are homeless. So we have peer supports that are really helping to identify different housing options, helping with employment needs from resume writing and interview skills to help obtain work. So we've had a lot of success in our employment department, that  I also am able to supervise those great people doing unbelievable work.

We have a hospital navigator. So this person does a lot of wraparound services when members are discharged from the hospital. They are really making sure that that gap between, before they get their medical appointments set up and psychiatrist appointments, they are making sure that members are getting to these appointments and have the support that they need in between those 3 and 5 day visits.

Then we have acting navigators which work in the field, as well, with a full clinical team. These are at-risk members with Serious Mental Illness. Then, where I started out, which is our health awareness coaches, they are working in what Dr. Wells already described as our Healthy View to Wellness Center program. They are doing everything from obtaining goals, teaching wellness classes, WHAM, smoking cessation, diabetes, classes on chronic pain, and our diabetes wellness program which was developed around the factors of WHAM. So, the peer support have been essential in our wellness program at really motivating our members to really take a look at their whole health goals -- not just about relationships and boundaries, but stress management and what kind of nutrition they are doing in their physical fitness goals.

On Fridays we do our WHAM class, which really helps with, it's an evidence-based process we are really trying to help activate self-management skills. So, we do, we help members to get, we use their strengths to help them to develop a goal. Then we have weekly meetings where we break it down into small, achievable goals that members can meet. Then every Friday, we will have a WHAM class and talk about the successes, barriers,  and maybe what the next steps are going to be. Then, the last piece of that is we have members meet with the peer support to talk on this one-on-one. But we've found a great deal of success with this program.

So after graduating in the wellness program, we have an alumni program, where we will do a little more advanced stuff like helping with employment or volunteer goals. They can come to alumni and start to look at more goals, again, it's still utilizing the WHAM for this. Then they also can do what Dr. Moher also talked about, which is our  Member and Family Advisory Council. This was developed really to give members a voice that are receiving services here at Assurance. The members lead the group discussions and they provide feedback to staff for our agency, like improving access to care or service or new groups. We've been able to develop a community garden and a thrift store. And a lot of volunteer opportunities. So I feel like it's really given our members, to be

empowered by being able to have a voice in what's working and what's not working.

So before we move  to outcomes, I think it's really important to talk about what I believe are the keys to success of the peer support staff of our agency. And maybe, the lessons that we've learned. And I think the hugest component for us has been the management buy-in from Dr. Moher to our CEO to Dr. Wells, who have supported the peers in ways...I can't really express how grateful I am for the support that they have given us. And they really saw the value of the peer support. So the recovery culture has been, it's the best place that I've ever worked, by far, hands down. I feel like we're all really working as a team. I'd heard about integration for a long time, but this is the first time i've really seen it in motion, where the peer supports...I mean, Dr. Moher really was in a cubbie with the rest of us. They are so approachable. The most amazing upper management people that I've ever seen, which has that trickle-down effect. I think when people feel valued, they do better work. They have better job, love for their job. At least I do, and that's the feedback that I hear.

I think another piece has been having clear roles for the peer support, really. Having a supervisor who understands these roles. And I know that that's me. But my supervisor has had also, a great understanding of what their roles are in helping to really make clear lines on what each role has been. And I think our staff has a tendency to work harder than most of the staff. And I think that's because they are really passionate. So I think it's important to talk a lot about self-care and about boundaries with work. So I personally have a weekly meeting where the peer staff can talk openly about barriers and successes in their work, as well as what they're doing in their life for self-care.

Then there's also individual supervisions where people can talk about their goals. Obviously, we have to talk about productivity and a lot of the pieces that none of us like. But probably, we have had the most success in that area with the peer support for some reason.

Lastly, we will talk about...training  is really important, Assurance does a lot of promoting from within, helping people to reach their personal goals. So a lot of our peer staff have been promoted to supervisors, leads, case managers, employment specialists, housing specialists, hospital navigators. So depending on their goals, we are pretty committed to help people get where they are going.

So I believe all these factors have led to greater job satisfaction and as a result, peer staff have a greater impact on our members. So I will turn it over to Dr. Wells who will share some of [inaudible].

>> CHRISTINE WELLS:  Thank you, Joddi. I think you have heard from both Dr. Moher and Joddi, they've shared with you, really, why we all do what we do. I get the ability to share with you a little bit about the evidence of why it works. It's not just because we enjoy it and are passionate about it, but it actually makes a difference in ways I had never seen before when working in community mental health.

I just want to talk a little bit about the outcomes we have seen. The peer support interventions can result in greater access to care such as primary care, more positive health experiences and actual improvement in health status. The cost reduction comes from better health outcomes, and I think being able to show to payers that this makes a difference is certainly something we are working on and it's important to do.

I'm going to show a few examples of the impact that we've had that we attribute to having peers involved in the work we do.

On this slide, if you look on the left is data from our clinics. On the right is some local comparisons. So we've seen significant involvement in employment services as Joddi mentioned, this is provided by peers support folks. 65% of the individuals struggling with Serious Mental Illness that we work with have been involved in our employment services. 13% of the SMI population in our county is employed, I think, it's pretty impressive,

that we have been able to engage in employment services 65% of those we work with.

We see more access to housing. Less than 2% of individuals struggling with Serious Mental Illness are homeless in the population we work with while, in our County, the homeless at 4% are SMI

Then, greater access to preventive care and annual wellness visits. So Arizona Medicaid sets a goal of 85% of individuals in the general population having a wellness visit. Our local county  for the SMI population is about 88%. We are able to have 96% of our individuals who are struggling with SMI have a wellness visit in the past year. About 60% of those folks, we are the primary care doc for. The other 40% we are not. Yet we are still able to help them get the preventative care visits. And a lot of that really comes from the peers. Our peers talk to them about their health. They talk to them about their primary care doc, when have you seen them? [indiscernible] before their visit and they will attend with them. And for many folks who haven't been or are anxious about going, having somebody go with them who can advocate for them and just be a support has made a big difference, as you can see, in terms of us being able to ensure they can access to that care.

The Healthy Youth program is our wellness program that both Dr. Moher and Joddi have talked about. Half the staff in that program are peers. Yet I think they provide more than half of the actual services. It really makes a difference, particularly in the engagement and getting people to come in. It's a nine week program, five days a week for six hours a day. If you think about it, it's hard to get anybody to do that. Yet we are get able to get people to really get hooked in and the peers are a big piece of that.

In that program we've had over 200 people graduate. 72% of them report an improvement in their perception of their own health. 63% report greater self-esteem. 95% report satisfaction with services, which I think indicates a positive health experience.

In terms of actual health changes, 47% have lost weight. 36% who lost weight lost more than 5% of their body weight and that is considered a significant reduction. 89% showed an increase in cardiac stamina, cardiac health. So they're able to walk faster, quicker, and less exertion. And, 80% show good blood pressure control.

The diabetes self-management program, Dr. Moher talked about, and he talked about the role of the peer, the peer participate in the [indiscernible] and groups that are led by our nutritionist. But the peer also works with the individual in their home in between groups, really trying to provide practical, in-between support and to apply practical behavior and facilitate real change. Making sure people have a way to cook healthy food or get to healthy food at the store. Working with people based on their living situation. What we see for our diabetes program, 89% of the folks who have gone through that report that they feel their health is better. 72% show a decrease in depressive symptoms. 78% report a reduction in anxiety symptoms. And in terms of blood sugar control, the [indiscernible] goal for the primary care docs for the general population is that those with poor control are less than 43%. We have 12% participating in the program. Who have [indiscernible]. So 82% have good control.  This is [indiscernible]. And, 94% report satisfaction with services showing a positive health index experience.

With regard to the opiate program, we have been able to decrease the dosage and the cost of opiates in [indiscernible].  We use a [indiscernible] approach to living with chronic pain and we have peer support folks involved in this, as well.

I think a lot of our success has really come from our focus on wellness from the beginning. But to foster a culture of health and wellness for our members, you really need to foster that for staff, as well.

Here I'm showing a list of examples of activities that we've done supporting staff with choosing a healthy lifestyle. We offer flu shots on

site every year as well as education about flu shots. We have a gym for a wellness program. We [indiscernible]. A lot of other things are listed there but I want to mention some of the awards we give. Every month we have an all staff meeting, give updates about what's going on, and we recognize the number of staff each time. Often, it's recognizing things that they are doing to promote integrated care or the impact they had on a particular individual.

For me, it's been very enjoyable to observe staff changing their own behaviors. We've gone from having donuts to bagels and fruit at meetings. I see staff walking with other staff and I see staff walking with members rather than sitting in an office with them -- out walking in the neighborhood, which I think allows people to maybe talk more openly about some of their challenges as they are walking off the anxiety, not to mention that way the staff and the member gets activity.

I think this [indiscernible] allowing them a real genuine  support and understanding how difficult it is to change behavior. I had a staff member tell me if he is asking a member to do something, he should be willing to do it in terms of healthy behavior.

I've seen a greater connection among staff. People really love coming to work. I hear it almost every day, somebody telling me and they love their job. And assisting greater team collaboration. There is very little inter-fighting or hierarchy. And I think this makes a difference in how we work with members. Members frequently say they feel very welcome here and they love coming. And our growth, I think, has shown that, because much of that is word-of-mouth between members.

They mention that people really focus here on the positive, it's not so much on their negative symptoms. And I think that has been a strength for us, is really focusing on the health and wellness. We talked about that a lot.

What I would like to share with you right now is a video of some of our members talking about the impact integrated care has had for them. These are all members who participated in our wellness program.

>> ROARA MICHAEL: Thanks, Christine, and I just want to tell everyone who's listening that I am about to launch the video. If you don't hear any audio, just click on Stop Listening to Presentation at the bottom of your screen.

[VIDEO PLAYING]

>> FEMALE VOICE: Assurance is an integrated clinic. We provide [indiscernible] we have primary care physicians in-house along with nurses, medical assistance, psychiatrists, and then we have our nutrition, pharmacist staff to help coordinate their care as well. We take a whole health approach here at Assurance when working with our members. We take into consideration their physical health, their mental health, if there's any substance use, any family needs. Our main goal here at Assurance is to promote an independent, healthy, life for our members.

>> FEMALE VOICE: It's been a wonderful experience considering that last year, when I came to Assurance, it was like, the last straw for me and I said, "This is it. I've had it. If you guys don't help me I'm done." They told me we've got primary care here. We've got behavioral health care here. And we've got the wellness program, which is a nine week program that I started. And it was wonderful. When I started it, I started losing weight. I started feeling good about myself. My anxiety levels were dropping and I wasn't going to the hospital every anymore. Every month they would say, "Maria, how many times did you go to the hospital this month?" and I would be like, "None!" And I got my teeth fixed, something that I've never had done to me. My teeth, oh my god! They were also treating me for prediabetes. I don't have that no more. They had me on a treatment [indiscernible]. And also Dr. Moher, he took me off that already. You don't need it no more. They did my [indiscernible] check, I'm not prediabetic no more. I mean, they did a whole thing the other clinics

have never done for me and it's just like, fascinating. You don't hear too much of people bragging about clinics. But I'm bragging about this one, I am, because honestly, I wake up in the mornings and want to come here. I appreciate everybody. I appreciate them here.

[END VIDEO]

>> ROARA MICHAEL: If you didn't get a chance to see the video we will be sending out the slides with the link to see the video at a different time. Thank you, Christine.

>> CHRISTINE WELLS: Thank you, I think we're ready for questions now.

>> ROARA MICHAEL: Thanks everyone, I'd really like to thank the presenters today for sharing. We're going to hop into questions. We had a bunch of questions come in so we will try to get to all questions, as many as I can, and the time that we have.

I'd like to jump up in the presentation and we had a couple questions come in for Christian. Christian, what behavioral health EHR are you using?

>> CHRISTIAN MOHER: So we use a product called Next Gen, it's not a behavioral health EHR for say, electronic health record. It was built as a primary care record. But the vendor that we got this product from, its name is Topaz. They are the ones that do all the mental health program for that electronic health record. Our problem with searching for records was that there were some that were pretty good for mental health but they were very bad at primary care, and some that were pretty good at primary care but didn't have any capability for mental health. So we bought this product -- which is not the cheapest product out there. We looked a lot at the other ones, the big ones like [indiscernible] Cerner and Allscripts and all that stuff. But this one we felt like was the best combination of primary care, and then, with our vendor, Topaz, gave us the best chance to be successful on a mental health standpoint, too. They built our templates for mental health, and our record is entirely one record. We have one

record, one care plan that everybody has access to and that makes it much easier for us.

>> ROARA MICHAEL: Great, thank you. Our next question could really be answered by anyone that we have on the line here. When [indiscernible] the cost of integrated care, how difficult was it to get staff for providers to buy-in to the concept and [indiscernible]?

>> CHRISTIAN MOHER: I will start and I think Christine will have some advice, too. It wasn't hard at all. When you talk to people about what we are doing, it sounds like a freaking awesome idea. Of course, we should all have integrated care! I would love it if, when I go to my primary care doctor's office and I could see a nutritionist or a pharmacist or get some fitness advice or see a psychiatrist if I needed to. On an intellectual level, I think it's easy to understand our model.

I think the other benefit is that we've built this from the ground up, so everybody that we hired was buying into working in our system. It's much harder if you're an established system already, when you try to plug in primary care to a mental care health network or vice versa. I think it's harder because people have their defined roles and expectations. We had no definitions for those roles and expectations and made it clear from the very beginning that if you weren't invested in integrated healthcare that we were not the right place for you. Christine?

>> CHRISTINE WELLS: Yes, exactly. I can add a little. I think we developed a reputation. So some of the people who apply here come saying, "I've heard what you do. I want to be a part of that. I'm excited about that." In our interviews with staff, we talk about our integrated model. We ask them their thoughts about that, whether they have experience with that. So it's pretty clear what is expected and what it will be like before they come on. With that said, I would say that, particularly with our case management staff, that's been the model for a long time in Arizona, in the Medicaid system. And, some people come in and they struggle to focus on the whole health.

So I think, initially, we probably had significantly more turnover than one would want because some people would struggle to make the change. But it's part of their expectations and that's part of their performance evaluation. If they are not able to make the change, they often end up leaving. We try to do as much as we can upfront. We do a fair amount of training, ongoing, with folks and try to work with them to make sure it's a fit for them.

>> ROARA MICHAEL: Great, thanks. I'm going to jump to EHRs again. This person's referencing, you discussed there are decent products out there that you can work with. That is in reference to health information technology. Can you just discuss why you chose the EHR that you did?

>> CHRISTIAN MOHER: Yeah. We had been in several meetings with several of the vendors and I don't even remember the names of most of them. Like I said, some of the big ones like Allscripts and Cerner. I can't remember them all. I think that what sold us on this product was Topaz, what we perceived to be their excitement over integrated care. I think we felt like they really wanted to be the leader in developing an electronic health record that worked in the integrated space, because there are unique needs for that system. So I think it was their salesmanship that got us on board at the beginning.

I've got to be honest with you, we had a lot of challenges at the beginning with Topaz and Next Gen, getting it to work, how we wanted it to work. If we had had this talk a year and half ago, then it probably wouldn't be as excited about Next Gen as I am now. They have some new leadership and new guidance at Topaz and that really has made a difference in how we work.

Another huge part of this electronic record for us is our population management capabilities. We can basically run any kind of report on any kind of demographic or outcome that we want from this system. So it is very robust. We have a population health administrator which is a

requirement of an agency like us, especially as we moved into value-based purchasing. So getting her the information that she needs in an easy way is a critical part of what an electronic record has to do for us, as well.

>> ROARA MICHAEL: Thanks, Christian. Maybe this one is for Christine, as well. Are your peers paid or volunteered? If there is paid, do you have volunteers? And how do you go without having volunteer peers?

>> CHRISTINE WELLS: We actually pay them all. We don't have volunteer peers. It's an established staff position. Job description, pay range, all that. And we pay them all. We value what they do. We see them as an integral part of our team. So, we treat them really, the same, as any other position.

>> ROARA MICHAEL: Great. So what are your suggested best practices for recruiting peer support and how do you financially reinforce and manage peer support team members?

>> CHRISTINE WELLS: I think, in recruiting, we've been really lucky, because people know each other. Many of our peers have been in services and they know others and they know who's worked in the services. Arizona has had a peer support training program, there's a certificate that they get. And, that's been around for a number of years. Many of them worked initially in detox centers and other places. So a lot of it has been word-of-mouth. Then, Joddi has been really important in helping, kind of, in the interview, asking the right kind of questions, getting a sense of how someone is doing in their own recovery. We've typically required that they've been in recovery for more than a year before we considered them. The word gets out. So, people want to come. It's probably been the easiest position for us to fill.

>> JODDI JACOBSON: Absolutely it's been the easiest position. We've had the least turnover with the peer support staff. I think interviewing is essential. The trick is, the peers are generating a significant amount of

revenue, so that generally is enticing to a lot of us. So in addition to doing really great work, they generate income, as well.

>> CHRISTINE WELLS: In Arizona, peer support folks can bill for lots of services. There is a peer support service but they also can do skills training or health promotion and even some case management. So we are able to have it be a position that generates revenue. In terms of supporting them, I feel that one of the really important things has been supervision by a peer. So, some of what Joddi focuses on certainly is their direct work in the direct service they are providing. But she has always, from the beginning, taken the time to check in with people about how are you doing with your recovery? In making it a point to address that personal aspect with them. And I think that has helped many of our peers to manage the stress of the job.

>> JODDI JACOBSON: Yeah.

>> ROARA MICHAEL: Great, thank you. Is there a certification process or required training for the peers you hire? In addition, are they full-time or part-time employees?

>> JODDI JACOBSON: There is a certification process. There's a 10-day training program. It used to be 40 hours. I think it's a little closer to 60 hours for peer staff. So they do need to be certified to work here. And they are all full-time. We don't have any part-time peer support staff -- not that we're against that, that's a possibility, as well, but all of our peer staff are full-time.

>> ROARA MICHAEL: Thanks, Joddi. I guess this question is for everyone. Do peers have access to the EHRs?

>> JODDI JACOBSON: Absolutely. They have access to all of the notes from therapists to docs. I think it's important to be transparent if we're working as a team, for all the members of the team to have access to all of the documentation.

>> CHRISTINE WELLS: We do do training on confidentiality and "need to know," and do talk about that with them. But we found that really, it's helpful for people to be able to take a look. For example, if a peer support person is working with a member who saw Dr. Moher last week and the individual doesn't really remember what Dr. Moher suggested, the peer support person can go in and look at Dr. Moher's note and help remind the person and work with them. So it's just made a difference so people can share information in an efficient way.

>> ROARA MICHAEL: Thank you. I know we had a couple questions come in, can you describe the role of the peer support staff and how that is different or very similar to case managers? So what are the similarities and differences of those job roles? And what is the productivity expectation for both?

>> CHRISTINE WELLS: I think the difference is here, so the case management is really the hub of the wheel, the person that's really in charge of making sure that the member gets the services that they are looking to get -- so, from primary care to peer support or therapy. The peer support is a little more on the front line in terms of, that they are the person who is going to walk the member through this journey. So they will do, I think case management is a little more of the paperwork piece. Although there is a connection that happens, it's not nearly as extensive as the work that the peer support does in the connection factor.

Then, expectations, so they are expected to do four to five hours a day of direct service. So depending on the role, because sometimes there is a lot of travel that's involved, but that is the expectation. The expectation is the same expectation for peer support as it is for the case managers. They bill at the same rate, actually, and don't have much trouble meeting those expectations.

>> ROARA MICHAEL:  Great, thank you. I think this question might be for Christian. Who is responsible for data collection and outcome measurement in your agency?

>> CHRISTIAN MOHER:  It's a fantastic question. The reality is we are all responsible for data collection. I can tell you, I was one of the biggest offenders because I am an old man and I put things in a certain place in the medical record where it was not accessible to our [indiscernible] health administrator. I think what the question is getting at is, is there a specific point person in charge of organizing and collating that data and making useful reports out of it? We do have a population health manager that does that and she is amazing at that job. We are required to have that position with our contract that we have with our state. And I'm very thankful that we d,o because she is amazing at organizing all that information and collecting it and getting all the providers -- including me, finally --  to put data into the record so that she can get it out when she needs to get it out.

>> ROARA MICHAEL:  While we are on the topic of outcomes, I think this one is for Christine. What specific outcome measures do you use for the outcomes [inaudible] improve health?

>> CHRISTINE WELLS:  It can vary a little bit by condition, but for our wellness program, we use the Duke Health Profile which gives the perception of health on a numbered scales. We use the PH29 [sounds like] to address depression. The [indiscernible]  for anxiety. We use the six minute walk, which, I got it from the [indiscernible] website. I'm not sure who developed the six minute walk, but it's how far you walk in the six minutes and allows you to look at the difference over time for what somebody can do. We take vitals, blood pressure, weight, waist circumference, we calculate the BMI - though that may not change a lot, even if they've lost weight. And we try to do a basic metabolic count for labs. The A1C if they are diabetic. For the smoking cessation, we use carbon monoxide breath meter. I think that's all of them.

>> ROARA MICHAEL: Thanks, Christine. We just have time for a couple more questions here. What are some challenges you experience with the peer providers as well as LCSW/licensed clinical social workers and psychologists who help in that effort? This particular person is coming from a hospital in a rural community and they just want to know if this capacity works for them.

>> JODDI JACOBSON: I think, again, we haven't really struggled with -- I've heard this before, so it's not the first time I've heard that there's been struggles in how to hire and recruit peer support, but we have not had that trouble. I really am looking at how secure people are in their own recovery before they start working here. So that's a lot to do with our interview process. And now it's really been word of mouth. People really want to work here because the recovery culture is amazing.

>> CHRISTINE WELLS: In Arizona, the certificate program, the training program, has been around for at least five years. So there is a strong recovery culture and and use of peers in the behavioral health system. That's been around for a while. In terms of hiring licensed social workers, that's the challenge. There aren't enough. It's very difficult, actually. We do have some therapists. But it can be a challenge. And then, psychologists, I'm probably one of a handful in the system. Most don't seem to be working in the behavioral health system. I'm hopeful that with an integrated model, more psychologists will be attracted to the field.

>> CHRISTIAN MOHER: If I can just chime in, I think that the rural areas are an ideal place to have peer support. Often, they are people who live in the community. I think that we just have to make sure that like Joddi said, they are strong and secure in their own recovery and that they have guidance from a case manager, as well, to help them. There are entire models of care based on peers and care managers coordinating with a physician or a therapist or psychologist to help manage care for those people. So I think it would be an awesome idea in the rural area.

>> ROARA MICHAEL: Thanks, everyone. We're going to go ahead and move on to resources. So Larry can go ahead and move on to resources for the last minute or so.

>> LARRY FRICKS: Thanks, Roara, and thanks, presenters, you are fantastic. We often send out a toolkit, Meaningful Roles for Peer Providers in Integrated Healthcare. We think...that's about a 120 page toolkit really gives them job descriptions, hiring programs that work well, HRSA programs, [indiscernible]. It's a great resource. Then, we talked about the WHAM training. There's the website, all the materials are available on the website. WHAM is undergoing a randomized study that will be published this year, hopefully, by Dr. Peter Cook at [indiscernible] for [indiscernible] outcome.

The last thing we have that is so important is telling your wellness story. We created this template. It really helps make your story more concise. You share some of the past but you move pretty quickly into what works for you and we use this for peer presentation at regional meetings. And they have been the highest rated activity of our meetings. The peers, they have all used this template.

Thank you, all. Roara, are you going to wrap this up for us?

>> ROARA MICHAEL: Thank you, I would like to extend a huge thanks to today's presenters for joining us on today's webinar. Once again a recording and transcript of this webinar will be available on the CIHS website. Once you exit the webinar you will be asked to complete a short survey. Thank you again everyone, and have a great afternoon.